BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SUDHIR K. GOEL, M.D.** Holder of License No. 27103 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-03-1030A **CONSENT AGREEMENT FOR DECREE OF CENSURE AND CIVIL PENALTY**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Sudhir K. Goel, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

SUDHIR K. GOEL, M.D.

DATED: 3/31/2006

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 27103 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-1030A after receiving a complaint regarding Respondent's medical record documentation and billing practices while providing services at an extended care facility ("Facility").

4. Facility informed the Board that the progress notes of one patient, B.S., appeared to be photocopies of one note with multiple dates of service added.

5. Facility stated that an internal review of Respondent's records revealed that in one patient record several progress notes were found that did not have the patient's name stamped on them and contained notes to the effect of "patient seen, note dictated." There were no corresponding dictated notes in the patient medical record. In another patient record, an identical progress note was found 14 times, each having a different date, ranging from March 22, 2003 to September 5, 2003.

6. Facility also indicated that a number of patient encounters recorded by Respondent may have been fabricated. Facility provided a list of 19 patient encounters for which they could not determine if Respondent had face to face patient visits.

7. Respondent admitted to using a hand held electronic device to record patient encounters from May 22, 2003 through September 9, 2003. In regard to B.S., Respondent used a saved copy of his previous note and entered the date of his current visit in order to prevent rewriting the entire note. Respondent stated that the records for B.S. look the same except for the date because his exam, findings, assessment and plan were the same on each of those days.

8. Board staff conducted a review of a sample of Respondent's records to determine the adequacy of his medical record keeping. Three patient records revealed the following:

A. Patient M.H. – The progress notes from July 9, 2003 through September 8, 2003 were identical. Respondent inserted photocopies of his original note into the record. Respondent's other progress notes were very similar and repetitive, although individually written.

B. Patient A.R. – The progress notes from August 15, 2003 through September 8, 2003 were identical and obvious photocopies. Other individually written notes were very similar and repetitive.

C. Patient I.E. – Four progress notes from September 2, 2003 through September 8, 2003 were identical and obvious photocopies.

9. Respondent's medical records make it appear that his long term patients with chronic problems are stable and that nothing changes week by week.

10. The standard of care required Respondent to see the patients he was treating. It also requires the medical records to reflect the condition of his patients to ensure proper continuity of care.

11. Respondent deviated from the standard of care because the medical records for his patients, during the time he used the hand held electronic device, and on some other occasions, do not reflect an individualized and accurate assessment of the daily condition of his patients.

12. Respondent's patients might have been harmed because Respondent's medical records did not reflect the true condition of his patients.

13. Board staff also reviewed 19 patient records and corresponding billing ledgers to determine Respondent's billing practices. The review found that Respondent

billed the insurance companies of 13 of the 19 patients and received payments from the insurance companies for 12 of the patients. In all, Respondent received $10,987.05 for services for which he did not have supporting medical records and failed to bill $4,515.01[1] for services for which he did have supporting medical records.

14. Respondent voluntarily completed the medical recordkeeping course offered by the Physician Assessment and Clinical Evaluation (PACE) program in April 2004. He received 17.25 hours of Category I Continuing Medical Education (CME).

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) – ("[f]ailing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(q) – ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(u) – ("[c]harging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has the same effect.").

[1] Contracted reimbursement amount

5. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(v) – ("[o]btaining a fee by fraud, deceit or misrepresentation.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for poor medical records and billing not supported by his medical records.

2. Respondent shall pay a civil penalty in the amount of $10,000. Respondent shall pay the civil penalty within 60 days.

3. This Order is the final disposition of case number MD-03-1030A.

DATED AND EFFECTIVE this 6th day of April, 2006.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 7th day of April, 2006 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 7th day of April, 2006 to:

Sudhir K. Goel, M.D.
Address of Record

_____
Investigational Review